PSYCHOGERIATRIC CARE AS A SPECIALIZED DISCIPLINE IN MEDICINE*

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IT is with trepidation that I, a geriatrician, speak to you who are experienced psychiatrists about the justification for psychogeriatrics as a special discipline. This is particularly the case since I must consider facts which already will be well known to you. However, I hope you will bear with me as I do this, since a logically argued case must go back to first principles.

From one point of view I feel no diffidence. As a geriatrician who has practiced in that specialty for almost 20 years, I feel that if I have any skill in advocacy this has resulted from the necessity, time and time again, throughout the years to convince a diminishing but hard core of skeptical colleagues that geriatric medicine is indeed a special discipline.

Today we have more than 300 consultant geriatricians in Great Britain; most practice in the specialty full time and operate a vast network of geriatric services. We have professorial chairs of geriatric medicine in 10 of the 26 medical schools in Great Britain and about half the medical students are receiving significant teaching in this subject. So, in geriatric medicine we already have trodden the path which psychogeriatrics is now beginning. At this early stage, however, psychogeriatrics already is receiving more support from psychiatrists than geriatric medicine first received from internists.

My essay is divided into two parts. In the first part I shall present the reasons for my belief that a specialized psychogeriatric service is needed. In the second part I shall describe the way in which such a service now is developing in Great Britain.

I do not believe that the practice of psychiatry changes rapidly when a

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patient reaches the years between age 65 and 70. However, the spectrum of psychiatric illness alters inexorably from the years around 50 to 60 to those from 80 to 90 and beyond. This occurs for the following reasons: There are two essential characteristics of the very old which alter the presentation of illness, whether physical or psychiatric. These are: 1) the almost universal effect of accumulated pathology and associated age changes and 2) the common intermingling of social and medical factors. These two facts combine to provide a background of complexity and precariousness which not only augments the superadded acute problem bringing the patient to the physician, but also often alters the classical presentation of disease.

Multiple pathologic and age-related changes include sensory deprivation (blindness and deafness); physical disability, whether simply from musculoskeletal disease (present in more than one third of those older than 65) or as a result of disease of the central nervous system (present in about 10% of those older than 65); metabolic vulnerability for a host of reasons; autonomic changes involving the bladder (predisposing to incontinence); posture (predisposing to falls); the regulation of blood pressure and body temperature; diminished oxygen perfusion to many parts of the body, which is compounded of many factors—for instance, an estimated 25% or so of those older than 65 suffer from disease of the respiratory system (based on data from Scotland), almost 20% have disease of the cardiovascular system, and about 8% suffer from anemia; and the local effect of atherosclerotic narrowing. Additionally, hospitalized old people are particularly prone to constipation, fecal incontinence, and the development of pressure sores.

The result of this multiple pathology—to which must be added the changes of aging itself such as loss of postmitotic fixed cells—is to produce an altered clinical presentation of disease and an increased sensitivity to the effects of drugs. The painless coronary thrombosis is well known. Perhaps less well known are painless peritonitis and fractures and the presentation, with mental confusion, of diseases such as miliary tuberculosis, subacute bacterial endocarditis, and thyrotoxicosis.

In the sociomedical component, I believe that few purely social problems affect the elderly; social breakdown is nearly always associated with a deterioration in health. The two go hand in hand. For example, there is little benefit to be obtained in treating depression in an old person through the use of tricyclic drugs if she wishes to be living independently and yet

has to spend the rest of her life in an institution because she has no relatives, has had a stroke, and has difficulty in getting in and out of bed and preparing her food. She requires skilled physical rehabilitation.

Of course, much mental illness in younger people also has a social component and psychiatry has developed a methodology to deal with this. Indeed, in this respect psychiatrists are much more aware of and prepared to consider the whole patient than are internists. Nevertheless, a unique combination of social incompetence, multiple pathology, and sensory deprivation in old age often leads to total disability. This must be dealt with in its entirety if the elderly patient is to obtain maximum happiness and satisfaction—something we should be able to offer today.

I am not sure that the general psychiatrist with all his commitments will be prepared to devote enough time to teaching and leading a team of nurses, social workers, and doctors to cope with these time-consuming and complex factors, many of which are not of themselves psychiatric, but which are inseparable strands in the tapestry of mental illness in old age. I do not say that the psychiatrist cannot do this, but experience suggests that he often is unwilling to do it.

Another reason I would give is based on the acute brain syndrome. Many old people already have a loss in the number and function of brain cells plus diminished cerebral circulation due to fluctuating blood pressure (possibly in association with posture or with varying cardiac arrhythmias), and atheromatous narrowing. To these are added diminished renal and hepatic function. Together, these mean that the aged brain is already precarious in its oxygen supply, therefore, highly sensitive to further oxygen deprivation, and particularly sensitive to toxemias and chemical poisoning (including the effect of drugs).

The result is that a vast amount of illness in old age presents with mental confusion, including: acute anoxia due to pneumonia, pulmonary collapse, or congestive cardiac failure; the effects of toxic substances such as drugs, alcohol, and insulin; metabolic toxins as in diabetes, uremia, liver disease, and myxedema; and vascular incidents as in cerebral infarction, hemorrhage, and transient cerebral ischemia.

Almost the whole spectrum of somatic medicine in the elderly may present with mental confusion. Indeed, as an aside it is interesting to note that the majority of patients referred to geriatricians come with one or more of four presenting symptoms: mental confusion, incontinence, postural instability, and immobility. There is, therefore, a need for close coopera-

tion between the psychiatrist and the internist or geriatrician; I believe this can be achieved best by joint assessment and management. Of course, this cooperation can be achieved by any general psychiatrist and general physician, but the evidence indicates, certainly in Great Britain, that they do not do so. Kidd in 1962 suggested[1] that 24% of patients aged 60 and over in mental hospitals and 34% of those aged 60 and over in geriatric hospitals were misplaced—the former having mainly somatic illnesses and the latter mainly psychiatric. More recently (in 1968) Mezey, Hodkinson, and Evans[2] compared patients aged 65 and older admitted to psychiatric and geriatric units and showed—perhaps because of the development of geriatric care in the meantime—a much lower figure: 8.2% in geriatric wards and 14.6% in psychiatric wards being misplaced. The misplacement had important consequences, since much physical or somatic disease remained undiagnosed in the mental hospital and much psychiatric disease went undiagnosed in the geriatric hospital.

Old people presenting with mental confusion and requiring inpatient care first should be admitted to a joint psychogeriatric assessment ward where their problems can be unravelled completely—in both their physical and mental aspects—by a psychiatrist together with a geriatrician. Separating such patients would have an additional advantage; elderly patients, because of their temporary noisiness and disorientation, often disrupt the management of acute illness in other patients in the general wards to which they are admitted. I do not think the elderly get a square deal in either the psychiatric or the general ward, and neither do the other patients.

Next we come to the great problem of dementia or the chronic brain syndrome, probably the most important medical problem which advanced societies will face during the rest of this century. In Great Britain several surveys agree in describing the prevalance of moderate and severe dementia in those over 65 as about 6%.[3,4] The rate of increase which we may expect in the next 20 years can be judged by considering the population changes. It is estimated that between 1971 and 1991 the 65-and-older population will increase by 16%, those 75 and older by 37%, and those 83 and older by 42%.

At present only 4.5% of those 65 and older are in institutions of any kind and less than half of those are mentally ill. This means that, now and for the future, the greater part of the burden of dealing with senile dementia will fall on the community, social services, domiciliary medical services, and particularly on families.

How are we to cope with this incredible problem? The first and most important answer, of course, is to discover the cause of senile dementia and how it can be prevented or cured. However, it surely would be overly optimistic to expect that even the present generation of middle-aged people will be affected by any discoveries made in the next few years.

Management, therefore, will depend, first, on meticulous diagnosis, particularly distinguishing between dementia and depression and picking out the small number of treatable causes of dementia, such as normal-pressure hydrocephalus, vitamin B_{12} deficiency, operable meningiomas, and other organic psychoses.

Second, there must be an organized system of community support, including day-hospital care, intermittent and planned admissions to either psychiatric hospitals or residential homes, and the provision of home care. These measures are designed primarily to relieve the pressure on relatives so that they may continue to shoulder the burden. Third, there is a need for special homes and long-term-care hospitals. These should offer a reasonable quality of life, since even the most disturbed respond to an optimistic and therapeutic environment.

Again, this is teamwork involving doctors, nurses, therapists, and social workers. The leader of such a team should be the psychiatrist. I must repeat that while work of this type is within the competence of any psychiatrist, very few are prepared to take it on. Indeed, in Great Britain at least, many psychiatrists will do all they can to avoid having to take over the long-term management of elderly patients suffering from dementia.

These are the main reasons why I think the psychiatry of old age is a special discipline, but I have not dealt with an additional group of psychiatric illnesses which occur in the elderly: the functional or affective disorders—the depressions, paraphrenias, other persecutory states, and personality disorders. Unlike all the others, this is a field which most psychiatrists usually are quite happy to accept and in which they will give sufficient time and attention to detail. However, here too the arguments about multiple pathology and a complexity of sociomedical factors apply. With this group of illnesses I also would emphasize that if a man's entire practice lies in the field of old age he will probably deal with these more effectively than will a general psychiatrist.

To summarize, the psychiatry of old age is a special discipline because the diseases are different in their presentation and require a different approach which entails a great deal of time and a unique organization of

psychiatric and social care. The psychiatry of old age is a special system of care and this is the fundamental justification for its existence. In Great Britain we have a nationwide network of psychiatric care (as in the United States). In addition, we also have a nationwide network of geriatric care. Between these two major services we see the third service developing, which will relate to both the others—psychogeriatrics.

In looking at the structure of this system of care I should like to report on current trends in psychogeriatrics in Great Britain, for this is the system I know about, and it is developing. To do this I must first say something about the structure of the geriatric service. This is based on the beds of the consultant geriatrician which, ideally, should be in the district general hospital, but which, in fact, may be spread over three, four, or more hospitals. Geriatric medicine is practiced as a form of progressive care and the beds are of three types. First, there is the acute or admission facility into which all patients are admitted first, usually from their homes and often after a home visit. Here a comprehensive medical and social diagnosis is made and treatment is initiated. From these beds many patients go straight home, some die, and others move on to the second stage of care. The second stage comprises the rehabilitation beds, usually in another ward, sometimes in another hospital. Here the accent is on the physical rehabilitation of disability. Again, from here many patients go home or to old age homes, some die, and a few move on to the third stage, that of long-term care. The long-term-care wards are also separate; the majority of patients remain in them for the rest of their lives. The average length of stay in the acute-care wards is, perhaps, two to three weeks, in the rehabilitation wards two to three months, and in the long-term-care wards two to three years. Only about one in 10 patients admitted to the acute-care geriatric wards ends up in the long-term-care ward, but because the length of stay is so long, they form about 50% of the geriatric-bed population (which at present is based on an establishment of 10 beds per 1,000 population aged 65 and older).

The other principal component of the geriatric service is the day hospital. This provides therapy without the hotel aspect of inpatient care. The day hospital may continue the rehabilitation process after patients leave the residential hospital or may serve patients who were never admitted to it. When rehabilitation ends and the optimal stage of independence has been reached, day-hospital attendance once a week may ensure the maintenance of function and independence which otherwise might slowly be allowed to

deteriorate. The day hospital also provides some social care for the disabled and allows certain medical and nursing procedures to be carried out without patients having to be admitted overnight.

This, then, is the skeleton of the hospital geriatric service. The psychogeriatric service also contains three of these elements, although these are separate from the geriatric unit: an acute or assessment ward, long-term-care wards, and a day hospital.

The psychogeriatric assessment ward is in the charge of a psychiatrist who specializes in the psychiatry of old age. Direct admission of patients usually is open to both the geriatrician and the psychiatrist. Each physician examines all patients; weekly case conferences are held to decide jointly where patients will go once the period of diagnosis, assessment, and treatment is complete. Often this presents no problems, since acute confusional disorders clear up when the underlying disease is treated. In the case of dementia, however, it does present problems and if long-term institutionalization is needed, the Department of Health and Social Security of Great Britain has laid down a formula attributing responsibility as follows:[5,6]

1) Ambulant demented patients should be cared for in old peoples' homes.

2) Demented patients who also suffer from severe physical disability should be looked after in long-term geriatric wards.

3) Demented patients who show severe behavioral problems should be looked after in long-term psychogeriatric wards.

4) Those with functional or affective disorders would be moved to the general psychiatric facilities of the psychogeriatrician.

The success of the entire system depends on the continued turnover of patients in the psychogeriatric assessment wards, where the maximum stay should be 28 days.

The psychogeriatrician also will have a day hospital. The norm which the Department of Health and Social Security has agreed to is two places per 1,000 people aged 65 and older in the population served. This should be distinct from the geriatric day hospital, but they may be adjoining each other, sharing some common services.

I have presented the reasons I believe that the psychiatry of later life is a valid discipline within medicine and the lines along which development is slowly proceeding in Great Britain.

Every emerging specialty has struggled in its time. When I was a

student, surgeons questioned the need for orthopedics as an independent specialty, saying: "We have always looked after the fractures." A little before that time the same sort of things were said about pediatrics; psychiatry has undergone the same kind of painful emergence. Geriatric medicine is at this stage in most parts of the world, and I believe that psychogeriatrics is now on the threshold of passage from infancy to adolescence.

Specialization in geriatric medicine and geriatric psychiatry is not justified on the basis of a special organ or a special tool of investigational procedure. It is justified on the basis of a special system of care which neither internists nor general psychiatrists usually are willing to develop. If they do so, they commonly find that the work is so absorbing and demanding that before long they have become specialists themselves.

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